Disability and equity in global health

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Persons with disabilities have greater health needs and challenges with accessing health care. In poor countries this is aggravated by constraints in health care and by poverty. In order to reach equity in health, it is necessary to address the additional challenges faced by persons with disability.

Persons with disabilities are among the poorest and most disadvantaged in any population, with the worst health and poverty outcomes, and the lowest access to health and social services (1). Defining equity as "the absence of avoidable or remediable differences among groups of people" (2), implies that equity in health cannot be achieved without addressing the needs of persons with disabilities (3, 4). It is therefore necessary to act on the challenges persons with disabilities face in

accessing health care, particularly in poor societies as an essential part of addressing equity in the global health agenda. This article discusses the interaction between disability, poverty and equity in health, and a new agenda for practice and research.

Lately, addressing the needs of persons with disabilities and other vulnerable and disadvantaged groups has been emphasized as a prerequisite in eradicating poverty (5). The 2030 Sustainable Development Agenda (6), reflected in the Sustainable Development Goals (SDGs) (7), states that addressing the needs of and barriers faced by disadvantaged groups is a prerequisite for an inclusive and equitable society, further reflected in the pledge to "leave no one behind".

Disability is a contested concept. The dominant understanding today is based on the International Classification of Functioning, Disability and Health (ICF) (8), which understands disability as linked to health and functioning and being created in the interaction between an individual and society. The classification provides a framework for understanding and describing disability and the disablement process and comprises the components of body functions and structure, health, contextual factors, activity and participation. The model in presented in the international classification represents a merge between a medical model, linking disability primarily to the body, and a social model depicting context as the primary source of disability. Disability is seen as the outcome of the interaction among the components in the model and may be operationalised as activity limitations and/or restrictions in social participation. With this framework, the World Health Organisation (WHO) has estimated that persons with disabilities amount to more than 1 billion persons globally (1), of which 80 % live in poor countries.

The International Classification of Functioning, Disability and Health provides a tool for understanding and analysing disability as strongly influenced by a range of social and environmental determinants. The determinants interacting to create disability needs to be addressed to reduce or eradicate barriers for equity in health (9). Individuals with disabilities face a number of environmental and social challenges that not only impact directly on their health, but also on their access to health services. This can for instance be an inappropriate wheelchair that leads to further and more serious health problems, or it could be no access to mobility devices reducing a person's ability to move from the home to the health facility. Another example could be maltreatment at home, for instance skewed distribution of food and family resources and denial of education and other forms of

participation. A third example may be health workers with discriminatory practices denying access to persons with disabilities.

Disability is associated with a diverse range of primary health conditions, higher risk for developing secondary conditions, and higher risk for comorbid conditions (1). Additionally, persons with disabilities have higher rates of health risk behaviour, are more exposed to violence and have higher risk for premature death. Bearing in mind that persons with disabilities have more health needs than non-disabled, it follows that they need more attention from health services than the general population to reduce the consequences of ill health. Distributing health services according to needs is named *vertical equity* as opposed to *horizontal equity* where everybody gets the same (health services) (10).

Access to health services has been suggested to comprise five dimensions that may be useful for analyzing barriers to health care for vulnerable groups. Firstly, *availability* concerns whether services are within reachable distance from where people live. Secondly, *accessibility* has to do with the structure of entrances and buildings. Thirdly, accommodation is about the services adapting to the needs of their clients. Fourthly, *affordability* is about the individual cost for someone to obtain services, and finally, *acceptability* is about services given in a way that is ethically sound and does not infringe on the integrity of the patients (11). If any of these dimensions are compromised, access is reduced. The dimensions may be used to disaggregate the concept of access and to compare between groups.

Developing countries

Most developing countries are committed to the Sustainable Development Goalss. They are thus obliged to produce accessible and quality services for vulnerable groups. Even though individuals with disabilities require more and specific attention from health services, current evidence clearly indicate substantial access barriers (1). For instance in one study persons with disabilities living in rural Namibia faced a major barrier in getting and paying for transport (12). Walking was often out of the question due to long distances and mobility problems. Paying for consultations and treatment was often impossible due to lack of money. Other barriers mentioned were negative attitudes and lack of knowledge about disability from health providers. A multitude of barriers interact for persons with disabilities living in poverty (13). It has been shown how people with disabilities face the same barriers as non-disabled but that the consequences of the barriers are aggravated due to their disabilities (14). A large WHO multi-country study showed

that around 80 % of persons with severe mental health problems in developing countries had no access to treatment (15). A series of studies by SINTEF, including data from nine countries in southern Africa revealed that between 10 – 40 % of persons with disabilities do not access general health care when they need it (see e.g. 16). The same studies revealed large gaps in medical rehabilitation and assistive device services. Thus, bearing in mind both the greater health needs, the extent of both general and specific (to disability) barriers, and existing evidence that persons with disabilities receive less health care in poor countries, health services are far from delivering equitable services.

The recognition of poverty as a key ingredient in producing and maintaining health inequity and with increased negative consequences for persons with disabilities (17, 18), invites particular efforts to eradicate avoidable differences in addition to the broad poverty eradication programs (19). With regards to health and health services, this implies firstly that we need to identify and target the mechanisms creating the additional health burden for persons with disabilities, to improve access to health services, and finally that health services need to adapt to the needs of persons with disabilities. Mainstream policies and action to improve services thus need to be supplemented with specific efforts that accommodates the needs of persons with disabilities. For health services this means reducing barriers such as physical access, negative attitudes and low awareness – and to increase competence of health workers to treat persons with disabilities in an equitable way.

Research

WHO, UNICEF, UN and the World Bank are all involved in developing a new generation of standards for disability statistics. The need for statistics on disability is explicitly mentioned in the Sustainable Development Goals (Goal 17). Capacity building in the least developed countries (LDCs) is required to enable monitoring and accountability of efforts towards sustainable development. Accessibility and quality of health services for vulnerable groups is in this regard one key area where data is needed.

A comprehensive EU funded (FP7) study, including household and individual survey data, carried out by SINTEF and partners (3) and including more than 9000 respondents in four African countries (South-Africa, Namibia, Malawi and Sudan), examined a range of barriers to access health care known from previous studies (Figure 1). The included barriers reflected the five dimensions of

access to health services as mentioned above (11). Disability was measured by means of a short set of questions developed by Washington Group on Disability Statistics (20), and threshold for qualifying as a person with disability was set low in order to include individuals with "mild", "moderate" and "severe" disability. The results revealed a consistent pattern with a higher proportion of individuals with than without disabilities reporting serious or insurmountable access problems (3). The main barriers are linked to transport, availability of services, costs and inadequate medicine and equipment.

Figure 1

The figure reveals a clear pattern showing more environmental barriers with increasing severity of disability. More access problems among those with greater health needs is clearly problematic from an equity perspective.

Towards a new agenda for practice and research

The current international momentum regarding disability issues (UN Convention of the Rights of Persons with Disabilities and the Sustainable Development Goals) promises to influence health policy and development of equitable services also in poor countries. The situation for individuals with disabilities in this regard can be understood as a marker for vulnerable groups in general and for the quality and equity of services more broadly (4). Disability has however not attracted the same type of interest as has been the case for specific diseases, such as HIV/AIDS, TB and Malaria. A range of humanitarian initiatives that raise and disburse additional funds for infectious diseases (Global Health Initiatives) have yielded substantial and measurable progress in reducing the burden of specific diseases and disabling conditions in low-income countries. The danger is however that strengthening and developing the health systems may be sidelined due to the pressure large international health initiatives put on health services and systems that are already under strain due to lack of resources (21). For health services to be equitable in practice require the ability to operate strategically, identify and sufficiently service individuals that may be hard to reach due to a range of barriers. Social and environmental determinants of health, i.e. for instance

discrimination, negative attitudes and low awareness of needs and rights, and availability of services, dangerous or inaccessible transport, may be even more important as targets for interventions than reforms and development within health services (22). It will be necessary to make transport available and affordable, educate both families and individuals with disabilities, ensure access to fundamental services for all, promote disability as a human rights issue, empower vulnerable groups, generate relevant data, etc. The foundation for such a development is inherent in the Sustainable Development Goals, which should be seen as a golden opportunity to promote equitable health and inclusive societies. Giving priority to disability in global health research is one important step in this direction.

Minibiografi

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